



**Form F**  
**Application - Food Establishment Permit**  
**Lincoln Board of Health**

Name of Establishment \_\_\_\_\_

Address of Establishment \_\_\_\_\_

Assessor's Map \_\_\_\_\_ Parcel Number \_\_\_\_\_

Name of Owner \_\_\_\_\_ Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_

Type of Permit	Applicable Laws	Fee
Permit to Operate a Food Establishment (Please $\checkmark$ one) <input type="checkbox"/> Year-round establishment (0-50 seats) <input type="checkbox"/> Year-round establishment (51 to 200 seats) <input type="checkbox"/> Year-round establishment (+200 seats)	105 CMR 590.000	\$150
<input type="checkbox"/> Seasonal (summer only) <input type="checkbox"/> Temporary (less than 15 days) <input type="checkbox"/> Non-profit corporation (i.e., church kitchen) <input type="checkbox"/> Daycare facility (13 or more meals per day) <input type="checkbox"/> Caterer's Multi Event <input type="checkbox"/> Caterer's Single Event <input type="checkbox"/> Bed & Breakfast Home (1 to 3 bedrooms) <input type="checkbox"/> Bed & Breakfast Establishment (more than 3 bedrooms) <input type="checkbox"/> Food Processor/Local BOH Registration	105 CMR 590.030 MGL Ch 94, s.328 102 CMR 7.11(2)(a) 105 CMR 590.033 105 CMR 590.034 105 CMR 590.034 MGL Ch 94, s 305C	\$75 \$50 \$0 \$50 \$50 \$25 \$75 \$75 \$0
<input type="checkbox"/> License to Manufacture Frozen Desserts	MGL Ch 94, s 65H	\$50
<input type="checkbox"/> Plan Review of a Food Service Establishment	105 CMR 598.058	\$100

I, the undersigned, hereby apply to the Lincoln Board of Health for the above-referenced permits in accordance with the listed applicable laws. I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes as required under law.

\_\_\_\_\_  
 Signature of Applicant\*

\_\_\_\_\_  
 By: Corporate Officer

\_\_\_\_\_  
 SS# or FID#

\_\_\_\_\_  
 Date of Application

**Permit will not be issued unless certification clause is signed by applicant. Social security numbers will be furnished to Mass. Dept. Of Revenue to determine whether applicant has met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made in accordance with MGL Ch. 62C, s. 49A.**

**Section A – General Information**

Establishment owned by:     Individual     Partnership     Corporation (state of corporation) \_\_\_\_\_

**Name & Address of each owner, partner, or corporate officer:**

<b>Name</b>	<b>Title</b>	<b>Home Address</b>	<b>Telephone Number</b>
_____	_____	_____	_____
_____	_____	_____	_____

**Local Agent of Partnership or Corporation if applicable:**

<b>Name</b>	<b>Title</b>	<b>Home Address</b>	<b>Telephone Number</b>
_____	_____	_____	_____

**Section B – Information about Food Service Establishment**

What is the total number of seats in the dining area? \_\_\_\_\_

Does this establishment have a bar area with a smoking section? \_\_\_\_\_ If yes, how many seats? \_\_\_\_\_

If there are 25 seats or more in the establishment, what are the names of the employees who are trained in anti-choke procedures?

**Section C – Temporary Food/Bed & Breakfast Establishments Only**

Please list the items on your menu (please attach if more space is necessary):

\_\_\_\_\_

\_\_\_\_\_

If you are applying for a temporary food service operator, please ask the Board of Health for Attachement #1